Diocesan Authorization for Medication Form

Date: _____

Student Name:_____
(Please print)

It is necessary that medication be given as follows:

Name of medication: _____
(Brand Name; also, Medication Name as it appears on container (if generic equivalent)

Prescription No.: _____

Color, if applicable: _____

Please circle form of medication:

Tablet Pill Capsule Inhalation Liquid Other/Specify _____

Dosage:_____
(Amount to be given)

How often/What time:_____

** No injection will be given, except in an extreme emergency, such as allergy to bee sting or the like.

The parent knows of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent or my office.

REMARKS:_____

_____

KNOWN ALLERGIES: _____

_____

_____ _____
Print Parent's Name **Parent's Signature**

PLEASE PRINT PHYSICIAN'S NAME: _____

_____ (_____)-_____
Physician's Signature **Physician's Telephone Number**